Medication Allergies: (if none put N/A)

Other Pertinent Clinical Information: (if none put N/A)

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Universal 17-P Authorization Form

Patient/Enrollee Name: ______________________________ **DOB:** ______________
Address (Street, Apt. #): ____
City/State/Zip: ____

Does the patient meet FDA-approved indication (current pregnancy is singleton and patient has a history of singleton spontaneous preterm birth less than 37 weeks of gestation)?

☐ Yes ☐ No

Current Gestational Age:_________week(s)__________days

Date Recorded: ________________

Is the patient currently receiving Makena? ☐ Yes ☐ No

Is the patient currently receiving hydroxyprogesterone caproate? ☐ Yes ☐ No

Complete and Sign Rx:

____
Prescriber's Name (Last, First)

____
Address

____
City, State, Zip

____
Practice Name Office Phone# Office Fax #

____
NPI # Office Tax ID #

____
Medicaid Provider #

____
Office Contact(s) Direct Phone #

____
After-hours Phone # Email

ICD-10 Code:

☐ O09.212 - Supervision of pregnancy with history of preterm labor, second trimester

☐ O09.213 - Supervision of pregnancy with history of preterm labor, third trimester

☐ O09.219 -Supervision of pregnancy with history of preterm labor, unspecified trimester

Preferred Method of Communication:

☐ Phone ☐ Fax ☐ Email

RX: (Select one product) Must be administered by a health care professional

☐ Compounded 17P *Medical billing use:* **J1729 (Compound)** – hydroxyprogesterone caproate, 10mg]

☐ Hydroxyprogesterone caproate injection 250 mg/ mL *Medical billing use:* **J1726 (Makena branded vial, Makena Auto-injector, or generic)**

- ☐ **Single-dose, preservative free vial** SIG: 250mg (1.0 mL) IM to upper outer quadrant of gluteus maximus weekly
  - ☐ 18-g needles & 3 mL syringe___#
  - ☐ 21-g 1 ½-needle ________ #
- ☐ **Subcutaneous Auto-Injector** SIG: 275mg (1.1mL) SQ to back of upper arm weekly

☐ Dispense 4 doses, X____ refills

Please Ship To:

☐ Prescriber ☐ Patient

Preferred Injection Setting:

☐ Healthcare Provider Office

☐ Home Health Care agency, if approved by insurance - weekly visit with maternal/fetal assessment and Makena/17HPC administration

- ☐ Agency name: ___________________________
- ☐ Health Plan Preferred Agency: ________________

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Desired Start Date: ______________________________

Desired End Date: ______________________________

I certify that this therapy is medically necessary and that this information is accurate to the best of my knowledge.

Prescriber's Signature: ____

Date: ____________________________________ ☐ Dispense As Written/Do Not Substitute

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